SECTION 745: INSTRUCTIONS FOR COMPLETING PREMIUM CONVERSION PLAN - BENEFIT ELECTION FORM, STATE ACCOUNTING FORM D-67

1. Purpose.

   (a) The PREMIUM CONVERSION PLAN - BENEFIT ELECTION FORM, SAFORM D-67 is used by an employee to enroll in the Premium Conversion Plan (PCP), to reduce compensation accordingly, or to change the amount of PCP reduction for the plan(s) enrolled in. This form is also used to cancel any previous authorizations made by a prior SAFORM D-67.

   (b) The form is also used by the agent (assignee) to initiate certain change transactions as required by applicable laws, rules, or regulations, when such use has been approved by the Comptroller; for such use, the forms are prepared by the agent (assignee) and do not require an employee's signature, but do require the authorization of the Health Fund.

2. Prepared By. The employee with the assistance of the appropriate office within the employing department or with the assistance of the agent (assignee).

3. Frequency. Prepared whenever an employee enrolls, changes enrollment or cancels a previous enrollment.

4. Distribution. Forms for new authorizations and cancellations must be submitted directly to the Health Fund for audit and eligibility review (after agent, if required). Upon approval, the Health Fund must submit forms for new authorizations to Central Payroll, DAGS, by 4:00 p.m. on the first work day of the month, if they are to be reflected in the payroll for that month. Forms for cancellations must be submitted to Central Payroll by 4:00 p.m. of the first work day of either pay period in a month, if they are to be reflected in that payroll period. (Health Fund, by controlling the submission of SAFORM D-67 to Central Payroll, may in effect control the pay period in which a new authorization or a cancellation will be effective.)

   (a) If completed at employing department.

      (1) Copy #1 - To agent for authorization signature; to Health Fund for review and authorization; to Central Payroll; to data processing center; and to Central Payroll for verification and control filing.

      (2) Copy #2 - To agent for reference filing.

      (3) Copy #3 - Retained by department for payroll verification and filing into employee's personnel jacket.

SECTION 745: INSTRUCTIONS FOR COMPLETING
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(4) Copy #4 - Retained by department, and routed to the employee for employee's personal record.

(b) If completed at agent's office.

(1) Copy #1 - To Health Fund for review and authorization; to Central Payroll; to data processing center; and to Central Payroll for verification and control filing.

(2) Copy #2 - Retained by the agent for reference filing.

(3) Copy #3 - To employing department for payroll verification and filing into employee's personnel jacket.

(4) Copy #4 - To employing department and routed to the employee for employee's record.

SECTION 745: INSTRUCTIONS FOR COMPLETING PREMIUM CONVERSION PLAN - BENEFIT ELECTION FORM, STATE ACCOUNTING FORM D-67

ITEM NO.	DATA AND DATA INSTRUCTIONS
(1)	DEPARTMENT - Enter the title of the department in which the employee is employed.
(2)	SUBDIVISION OR SCHOOL - Enter the title of the subdivision or school in which the employee is employed.
(3)	FORM NO. - Form number PK1 is pre-printed.
(4)	SOCIAL SECURITY NO. - Enter the employee's social security number.
(5)	LAST NAME, FIRST NAME, MIDDLE INITIAL - Enter the employee's name in the following sequence: last name, first name, middle initial. The name must be identical with the name reflected on the EMPLOYEE'S EARNINGS, DEDUCTIONS AND LEAVE STATEMENT. A comma must be placed between the last name and the first name; do not use a comma elsewhere in the name.
(6)	AGENT - Enter the code assigned to the agent (assignee) who is to receive the assignment. 701 - Health Fund 801 - HGEA 901 - UPW
(7)	DEPT. - Enter the one character code of the department in which the employee is employed.
(8)	EFFECTIVE DATE - Enter the date when the form is to take effect.
(9)	I HEREBY ELECT TO: /_/ A. /_/ ENROLL OR /_/ CHANGE - Enter an "X" in the first box if the employee is authorizing a reduction; and enter an "X" in the second box if enrolling in the Premium Conversion Plan (PCP) or enter an "X" in the third box if changing the amount of PCP reduction for the benefit plan(s) selected. /_/ B. CANCEL - Enter an "X" in this box to cancel any previous authorization.

SECTION 745: INSTRUCTIONS FOR COMPLETING PREMIUM CONVERSION PLAN - BENEFIT ELECTION FORM, STATE ACCOUNTING FORM D-67

ITEM NO.	DATA AND DATA INSTRUCTIONS
(10)	BENEFIT PLAN - Enter an "X" in the box for the Benefit(s) plan desired: Medical, Drug, Vision, and/or Adult Dental.
(11)	TYPE - Enter the assignment type code. DR - Adult Dental Premium Conversion Plan MR - Medical Premium Conversion Plan PR - Prescription Drug Premium Conversion Plan VR - Vision Care Premium Conversion Plan UD - Union Adult Dental Premium Conversion Plan UM - Union Medical Premium Conversion Plan UP - Union Prescription Drug Premium Conversion Plan UV - Union Vision Care Premium Conversion Plan
(12)	PLAN CODE - Enter the three-digit number plan code in which the employee is enrolled. Refer to Table I: HEALTH FUND PLAN CODES FOR PAYROLL DEDUCTIONS.
(13)	FIRST MONTH CONTRIBUTION - Enter the dollar amount that is to be deducted for the first month.
(14)	NEXT MONTH IF DIFFERENT - Enter the dollar amount that is to be deducted for subsequent months if different from the first month.
(15)	The date and signature of the employee.
(16)	The date and signature of the agent (assignee) and the authorized signature of the Health Fund.

SECTION 745: INSTRUCTIONS FOR COMPLETING PREMIUM CONVERSION PLAN - BENEFIT ELECTION FORM, STATE ACCOUNTING FORM D-67

TABLE I: HEALTH FUND PLAN CODES FOR PAYROLL DEDUCTIONS

PLAN CODE	TYPE OF PLAN
	MEDICAL
111	KAISER - Self Only
112	KAISER - Self and Family
211	HMSA - Self Only
212	HMSA - Self and Family
411	CHP - Self Only
412	CHP - Self and Family
511	ISLANDCARE - Self Only
512	ISLANDCARE - Self and Family
	PRESCRIPTION DRUG
311	HDS MEDICAL - Self Only
312	HDS MEDICAL - Self and Family
	VISION CARE
011	VSP - Self Only
012	VSP - Self and Family
	ADULT DENTAL
631	HDS - Self Only
632	HDS - Self and Spouse

EXHIBIT A: SAMPLE FORM KEYED TO INSTRUCTIONS FOR SAFORM D-67

USE TYPEWRITER OR PRINT WITH BALL POINT PEN WITH HEAVY PRESSURE

STATE OF HAWAII **PREMIUM CONVERSION PLAN — BENEFIT ELECTION FORM**

1 DEPARTMENT (1) | 2 SUBDIVISION OR SCHOOL (2)

3 FORM NO (3) PKI | 4 SOCIAL SECURITY NO (4) | 5 LAST NAME, FIRST NAME, MIDDLE INITIAL (5) | 6 AGENT (6) | 7 DEPT (7) | 8 EFFECTIVE DATE (8) __/__/__

I HEREBY ELECT TO

9 ☐ A. ☐ ENROLL IN THE PREMIUM CONVERSION PLAN (PCP) OR ☐ CHANGE THE AMOUNT OF MY PCP REDUCTION FOR THE PLAN(S) CHECKED IN COLUMN 10 (9)
I AUTHORIZE THE STATE OF HAWAII TO REDUCE MY PRE-TAX COMPENSATION EACH PAYROLL PERIOD BY ONE-HALF THE AMOUNT OF MY MONTHLY HEALTH BENEFITS PLAN CONTRIBUTIONS
MY AUTHORIZATION ABOVE ALSO INCLUDES ANY CONTRIBUTION INCREASE, DECREASE, ADJUSTMENT OR CANCELLATION AS REQUIRED BY THE HEALTH BENEFITS PLAN UNDER APPLICABLE LAWS, RULES OR REGULATIONS

☐ B CANCEL MY PCP REDUCTION FOR THE PLAN(S) CHECKED IN COLUMN 10

10 BENEFIT PLAN	11 TYPE CODE	12 PLAN CODE	13 FIRST MONTH CONTRIBUTION	14 NEXT MONTH IF DIFFERENT
☐ MEDICAL (10)	(11)	(12)	$ (13)	$ (14)
☐ DRUG			$	$
☐ VISION			$	$
☐ ADULT DENTAL			$	$

I HAVE RECEIVED AND READ THE PRINTED INFORMATION PROVIDED BY MY EMPLOYER EXPLAINING THE STATE OF HAWAII PCP AND MY OPTIONS THEREUNDER (15)

15 DATE 16 EMPLOYEE'S SIGNATURE

(16)

17 DATE 18 AUTHORIZED SIGNATURE

STATE COMPTROLLER (CENTRAL PAYROLL)

STATE ACCOUNTING FORM D-67
APRIL 1, 1990

GENERAL INFORMATION
(Be sure to read)

By electing to participate in the Premium Conversion Plan, I understand that:

1) My authorization will AUTOMATICALLY CONTINUE year-to-year for the duration of the plan until I terminate or change my participation in the Premium Conversion Plan (PCP) during an Open Enrollment Period;
2) If I have a change in personal status (e.g., marriage, birth or adoption of child(ren), divorce, etc.), I must complete and file
   a) Another Health Benefits Plan Enrollment Application,
   b) PCP Election Change Form (DPS/PCP-2), and
   c) PCP Benefit Election Form (Form D-67)

   all within 31 days of the event, to modify my reduction in pay, otherwise, changes can be made only during an Open Enrollment Period;
3) My election, in the absence of a change in personal status, is irrevocable for the current plan year; and
4) If I change or cancel my health benefits plan coverages, but my PCP change or cancellation is not allowable, my PCP Benefit Election authorization will still remain in effect until the end of the plan year, until the proper PCP change/cancellation forms are filed, and my payments will be forfeited.

NEW EMPLOYEES ONLY (INCLUDING TRANSFERS)

If reemployed by the State, you may continue your Premium Conversion Plan enrollment under certain conditions. (Ref: Section 14-51-23 (a) (4), PCP Administrative Rules)

Were you previously employed by the Hawaii State Government?

☐ No
☐ Yes My last date of employment: _____

My last State agency employer: _____

HEALTH FUND USE ONLY

☐ Administrative correction of error. No PCP Election Change Form needed.

EXHIBIT B: FILLED-OUT SAMPLE OF SAFORM D-67

USE TYPEWRITER OR PRINT WITH BALL POINT PEN WITH HEAVY PRESSURE

STATE OF HAWAII — **PREMIUM CONVERSION PLAN — BENEFIT ELECTION FORM**

1 DEPARTMENT	2 SUBDIVISION OR SCHOOL
Transportation	Highways Division

3 FORM NO	4 SOCIAL SECURITY NO	5 LAST NAME, FIRST NAME, MIDDLE INITIAL	6 AGENT	7 DEPT	8 EFFECTIVE DATE
PKI	575 | 20 | 8876	Inoue, Brian L.	701	D	07/01/90

I HEREBY ELECT TO

9 [X] A [X] ENROLL IN THE PREMIUM CONVERSION PLAN (PCP) OR [ ] CHANGE THE AMOUNT OF MY PCP REDUCTION FOR THE PLAN(S) CHECKED IN COLUMN 10
I AUTHORIZE THE STATE OF HAWAII TO REDUCE MY PRE-TAX COMPENSATION EACH PAYROLL PERIOD BY ONE HALF THE AMOUNT OF MY MONTHLY HEALTH BENEFITS PLAN CONTRIBUTIONS
MY AUTHORIZATION ABOVE ALSO INCLUDES ANY CONTRIBUTION INCREASE, DECREASE, ADJUSTMENT OR CANCELLATION AS REQUIRED BY THE HEALTH BENEFITS PLAN UNDER APPLICABLE LAWS, RULES OR REGULATIONS

[ ] B CANCEL MY PCP REDUCTION FOR THE PLAN(S) CHECKED IN COLUMN 10

10 BENEFIT PLAN	11 TYPE CODE	12 PLAN CODE	13 FIRST MONTH CONTRIBUTION	14 NEXT MONTH IF DIFFERENT
[X] MEDICAL	M R	2 1 1	$ 2500	$ 2000
[X] DRUG	P R	3 1 1	$ 2000	$ 1500
[X] VISION	V R	0 1 1	$ 2000	$ 1500
[X] ADULT DENTAL	D R	6 3 1	$ 2500	$ 2000

I HAVE RECEIVED AND READ THE PRINTED INFORMATION PROVIDED BY MY EMPLOYER EXPLAINING THE STATE OF HAWAII PCP AND MY OPTIONS THEREUNDER

15 DATE: 06/15/90 — 16 EMPLOYEE'S SIGNATURE: Brian L. Inoue

17 DATE: 06/20/90 — 18 AUTHORIZED SIGNATURE: John H. Smith

STATE COMPTROLLER (CENTRAL PAYROLL)

STATE ACCOUNTING FORM D-67
APRIL 1, 1990

GENERAL INFORMATION
(Be sure to read)

By electing to participate in the Premium Conversion Plan, I understand that:

1) My authorization will AUTOMATICALLY CONTINUE year-to-year for the duration of the plan until I terminate or change my participation in the Premium Conversion Plan (PCP) during an Open Enrollment Period;
2) If I have a change in personal status (e.g., marriage, birth or adoption of child(ren), divorce, etc.), I must complete and file
   a) Another Health Benefits Plan Enrollment Application,
   b) PCP Election Change Form (DPS/PCP-2), and
   c) PCP Benefit Election Form (Form D-67)

   all within 31 days of the event, to modify my reduction in pay, otherwise, changes can be made only during an Open Enrollment Period;
3) My election, in the absence of a change in personal status, is irrevocable for the current plan year; and
4) If I change or cancel my health benefits plan coverages, but my PCP change or cancellation is not allowable, my PCP Benefit Election authorization will still remain in effect until the end of the plan year, until the proper PCP change/cancellation forms are filed, and my payments will be forfeited.

NEW EMPLOYEES ONLY (INCLUDING TRANSFERS)

If reemployed by the State, you may continue your Premium Conversion Plan enrollment under certain conditions. (Ref: Section 14-51-23 (a) (4), PCP Administrative Rules)

Were you previously employed by the Hawaii State Government?

[ ] No
[ ] Yes My last date of employment: _____

My last State agency employer: _____

HEALTH FUND USE ONLY

[ ] Administrative correction of error. No PCP Election Change Form needed.